Benefit Options
Choice. Value. Health.

STATE OF ARIZONA COBRA ENROLLMENT/CHANGE FORM 2006/2007

☐ NEW ENROLLMENT ☐ QUALIFIED LIFE EVENT ☐ ADDRESS CHANGE ☐ TERMINATION

IDENTIFICATION

ENROLLEE LAST NAME, FIRST NAME, M.I.	Social Security Number	☐ MALE ☐FEMALE	☐MARRIED ☐SINGLE
STREET ADDRESS	COUNTY OF RESIDENCE	DATE OF BIRTH	
CITY, STATE, ZIP CODE	WORK PHONE NUMBER ( )	HOME PHONE NUMBER ( )	
EMPLOYEE LAST NAME, FIRST NAME, M.I.	SPOUSE'S EMPLOYER	EMPLOYEE EIN OR SSN	

MEDICAL PLAN SELECTION

☐ **I DECLINE MEDICAL COVERAGE**

CENTRAL REGION: MARICOPA, GILA, & PINAL COUNTIES	**MONTHLY PREMIUM SINGLE COVERAGE**	**MONTHLY PREMIUM FAMILY COVERAGE**
RAN+AMN EPO	☐ $444.72	☐ $1,102.11
Schaller Anderson Healthcare (SA) EPO	☐ $444.72	☐ $1,102.11
United Healthcare (UHC) EPO	☐ $444.72	☐ $1,102.11
Arizona Foundation (AZF) PPO	☐ $721.14	☐ $1,759.50
United Healthcare (UHC) PPO	☐ $721.14	☐ $1,759.50
SOUTHERN REGION: PIMA, & SANTA CRUZ COUNTIES		
RAN+AMN EPO	☐ $431.46	☐ $1,067.43
Schaller Anderson Healthcare (SA) EPO	☐ $431.46	☐ $1,067.43
United Healthcare (UHC) EPO	☐ $431.46	☐ $1,067.43
Arizona Foundation (AZF) PPO	☐ $664.02	☐ $1,598.85
United Healthcare (UHC) PPO	☐ $664.02	☐ $1,598.85
NORTH REGION: YAVAPAI, COCONINO, NAVAJO, & APACHE COUNTIES		
RAN+AMN EPO	☐ $588.54	☐ $1,461.66
Schaller Anderson Healthcare (SA) EPO	☐ $588.54	☐ $1,461.66
Arizona Foundation (AZF) PPO	☐ $753.27	☐ $1,876.80
SOUTHEASTERN REGION: GRAHAM, GREENLEE, & COCHISE COUNTIES		
RAN+AMN (HMA) EPO	☐ $588.54	☐ $1,461.66
Schaller Anderson Healthcare (SA) EPO	☐ $588.54	☐ $1,461.66
Arizona Foundation (AZF) PPO	☐ $753.27	☐ $1,876.80
WESTERN REGION: MOHAVE, LA PAZ, & YUMA COUNTIES		
RAN+AMN EPO	☐ $588.54	☐ $1,461.66
Schaller Anderson Healthcare (SA) EPO	☐ $588.54	☐ $1,461.66
Arizona Foundation (AZF) PPO	☐ $753.27	☐ $1,876.80
OUT-OF-STATE		
Beech Street PPO	☐ $772.14	☐ $1,920.66
NAU Only - Blue Cross/Blue Shield		
BCBSAZ PPO	☐ $551.74	☐ $1417.53

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STATE OF ARIZONA COBRA ENROLLMENT/CHANGE FORM 2006/2007 CONTINUED

DENTAL PLAN SELECTION

☐ I DECLINE DENTAL COVERAGE	MONTHLY PREMIUM SINGLE COVERAGE	MONTHLY PREMIUM FAMILY COVERAGE
DELTA DENTAL INDEMNITY/PPO IN ARIZONA AND OUT-OF-STATE	☐ $33.09	☐ $108.01
METLIFE DENTAL INDEMNITY/PPO IN ARIZONA AND OUT-OF-STATE	☐ $28.87	☐ $90.27
EMPLOYERS DENTAL SERVICE PRE-PAID PLAN IN-STATE-ONLY	☐ $10.40	☐ $30.25
ASSURANT (FORTIS BENEFITS) IN-STATE-ONLY	☐ $11.08	☐ $30.11

VISION PLAN SELECTION

☐ **I DECLINE VISION COVERAGE** ☐ **AVESIS SINGLE COVERAGE $6.47** ☐ **AVESIS FAMILY COVERAGE $17.52**

DEPENDENTS (MUST BE LISTED FOR FAMILY COVERAGE)

LAST NAME, FIRST NAME, M.I.,	RELATIONSHIP TO EMPLOYEE S=Spouse, C=Child, G=Guardian, P=Placed for adoption, T=Stepchild	BIRTHDATE (MM/DD/YY)	SOCIAL SECURITY NUMBER	MALE OR FEMALE	FULL TIME STUDENT Y or N	DISABLED Y or N
02 Spouse	☐ S					
03	☐ C ☐ G ☐ P ☐ T			☐M ☐F		
04	☐ C ☐ G ☐ P ☐ T			☐M ☐F		
05	☐ C ☐ G ☐ P ☐ T			☐M ☐F		
06	☐ C ☐ G ☐ P ☐ T			☐M ☐F		
07	☐ C ☐ G ☐ P ☐ T			☐M ☐F		

ENROLLEE AUTHORIZATION AND SIGNATURE

I hereby certify that under penalty of perjury that the information provided in this application for employee benefits, including address and spouse/dependent information is true and correct. I further acknowledge that I am aware that providing false information may subject me to a denial of employee benefits, disciplinary action, and potential prosecution pursuant to ARS Section 13-2310, 13-2311, 13-2702, and other applicable provisions of the law.

SIGNATURE:_____ DATE:_____

Return form to: ADOA Benefits Office, 100 N. 15th Ave., Suite 103, Phoenix, AZ 85007 **Revised 07/26/06**